

Novel Coronavirus (COVID-19)

Los Angeles County Department of Public Health

Guidance on COVID-19 Testing Priorities and Recommendations for People Experiencing Homelessness

This document provides guidance on Los Angeles County Department of Public Health priorities for COVID-19 testing among people experiencing homelessness and staff of facilities serving those individuals. These priorities are based on the elevated risk of transmission and spread of COVID-19 in this population. The guidance is informed by recent experiences of COVID-19 outbreaks in people experiencing homelessness living in other metropolitan areas in the U.S., and by priorities issued by the California Department of Public Health for people living in congregate settings.

This guidance is written for all providers of services for people experiencing homelessness, including health care providers, street outreach multidisciplinary teams, and operators of interim or transitional housing for this population. The implementation of this guidance at specific sites and facilities may require the partnership of various organizations in Los Angeles County, including the Department of Public Health.

The goals of the new testing guidance are as follows:

1. Identify COVID19 cases as soon as possible to prevent large outbreaks among people experiencing homelessness
2. Implement targeted testing among asymptomatic persons to identify cases prior to the development of symptoms in order to curtail disease transmission
3. Assure that staff and residents of homeless shelters, residents of homeless encampments, and staff of programs serving shelters and encampments are linked to care as needed.

To achieve those goals, the County has prioritized settings by level of transmission risk and by whether there has been an outbreak at the specific site. The assessment of risk is based on the degree of contact people are likely to experience in each type of setting. This prioritization, which starts with congregate sites at which an outbreak has already been identified, will help clinical providers prioritize testing as well as requests for County assistance with testing based on risk of transmission.

- A. Shelters / Congregate Settings – Outbreak Identified / Active Investigation
- B. Shelters / Congregate Settings – No Outbreak Identified
- C. Encampments – Outbreak Identified / Active Investigation
- D. Encampments – No Outbreak Identified
- E. Hotels/Motels designated during the current state of emergency for medically vulnerable people experiencing homelessness
- F. Medical Shelters for isolation and quarantine

Site-Specific Testing Guidance

While the table above reflects County priorities, shelter staff or outreach teams working with specific hotels, motels, or encampments with people experiencing homelessness may choose to embark on testing on their own as their resources allow. The testing approach for a specific site should take into consideration the site's physical layout; resident grouping, movement, and activities; the site's capacity to separate infected from uninfected persons; the site's access to tests and testing resources, including staff and personal protective equipment to conduct the testing; and test turn-around-times, as follows:

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- **Layout:** If the site has self-contained buildings or separate units within a building, each grouping of individuals within the site remains within one building or unit for all their activities, testing may be targeted to the area in which the outbreak occurred. If a site has no internal separations for residents, broader testing might be necessary.
- **Grouping, movement, and activities:** Testing should reflect patterns of interaction. If residents at a site sleep, bathe, eat, and attend programs with a set cohort of individuals and have no contact with others, testing may be targeted to those within a given group.
- **Risk for infection:** Testing may also be targeted to individuals according to their risk for acquiring COVID-19. Persons who move freely between the site, the community at large, and/or high-risk areas for COVID-19 are themselves at increased risk for infection compared to those who follow safer at home guidance to stay at the shelter. Persons newly admitted to a congregate site also differ in risk of infection depending on whether they are coming from the community or from a location where they may have completed isolation or quarantine.
- **Separation:** If an individual had symptoms of COVID-19 at entry and was immediately isolated, it may be appropriate to limit testing to those who were in the person's immediate vicinity prior to isolation. If isolation was not carried out or was not feasible, a larger group may need to be tested.
- **Resources:** If a site or a clinical team working with a site has private access to testing kits, they may choose to test all residents when there is an outbreak, rather than limiting testing based on criteria above.
- **Test turn-around-times:** Access to testing is most meaningful for disease control when the lab used has quick test turn-around-times (TAT). Ideally, the TAT should be less than 2 days, and in the population of people experiencing homelessness, same day to 1-day TATs are strongly preferred.

A few general points about using this guidance:

- In the guidelines that follow, we make recommendations based on the level of testing resources available in the County at the time testing is being planned, and outline both "high" or "limited" testing capacity scenarios. By high testing capacity, we mean that the County and/or the clinical team serving a site has access to test kits, staff, adequate PPE to conduct the testing, and is linked to a lab that will provide results within 2 days. By limited testing capacity, we characterize situations where the County and/or the clinical team serving the site is lacking test kits, staff, PPE or capacity for rapid test results. Assessing testing resources and availability is necessary to determine an appropriate testing strategy. High/limited capacity strategies are outlined here for each type of site on the County priority list. The County and the clinical partners providing testing services can adopt select portions of the testing strategies below, as befits their current testing resources.
- These guidelines also refer to "symptom screening" as a factor in determining the need for testing. Symptom screening entails asking the resident about their experience of chills, cough, shortness of breath or difficulty breathing, congestion or runny nose, fatigue, muscle or body aches, headache, sore throat, new loss of taste or smell, nausea or vomiting, or diarrhea. If possible, temperatures should be taken as well using a method designed to avoid transmission.



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- The guidance uses the terms “cohort” and “cohorting.” Cohorting refers to the practice of keeping individuals with the same COVID-19 status together to avoid transmission to uninfected individuals. People who are symptomatic may be kept apart from other people in one part of a facility so that those who are well are not exposed to infection. Cohorted areas should provide sleeping, bathroom, living, and eating areas that are separate from each other to avoid contact between infected and uninfected persons. If a facility has additional cohorting capacity, a separate area can also be set aside for new admissions who are awaiting test results, or for quarantining new admissions before they join the general population of the facility.

A. Shelters / Congregate Settings-Outbreak /Active Investigation

Where an outbreak has been identified, the Department of Public Health will investigate the site and work with partners to complete testing, isolation, and quarantine of individuals for rapid infection control. As previously described, a specific testing plan will be tailored to the size and layout of the shelter and resident movements within the shelter and requires assessment of testing capacity and resources as discussed above. The Department of Public Health will contact the site manager and any other partners to assess and coordinate the outbreak response and will notify the site of requirements and next steps. A blend of high and limited testing capacity approaches may be deemed appropriate after assessments of the facility and the extent of the outbreak.

High testing capacity:

- Conduct voluntary testing of all residents and staff in the shelter, regardless of symptoms.
- For residents and staff who test negative, offer repeat testing weekly until shelter quarantine is lifted and outbreak is determined to have been controlled.
- For residents who refuse testing, quarantine away from other residents. For staff who refuse testing, quarantine at home for 14 days before returning to work.

Limited testing capacity:

- Test residents and staff who are symptomatic.
- Test contacts based on the places within the shelter frequented by the confirmed case and identification of immediate close contacts (e.g. same dorm, same floor, etc.).
- For residents identified as close contacts who refuse testing, quarantine away from other residents. Staff identified as close contacts who refuse testing should complete 14 days of quarantine at home before returning to work.

B. Shelters / Congregate Settings – No Outbreak Identified

The testing plan should be tailored to the size and layout of the shelter and the resident and staff movements within the shelter and requires assessment of testing capacity and resources as discussed above. Facility managers and clinical teams providing services can adopt select portions of the high testing capacity guidance and provide a blend of high and limited testing capacity approaches as befits their testing capacity. Absent an

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identified outbreak, the role of testing is to identify COVID-19 cases quickly to allow for rapid isolation and quarantine and decrease further transmission. Access to shelters for people experiencing homelessness should not be limited by their test result or refusal to be tested. All shelters should identify appropriate housing options for clients based on test result, including referrals to isolation and quarantine areas or on-site cohorting strategies.

High testing capacity:

New admissions and re-entry residents

Sites admitting new clients into their facilities can consider implementing admissions testing since individuals coming in from the community may be unknowingly infected with COVID-19. Admissions testing may also be applied to residents who leave during the day and return at curfew, referred to as re-entry residents in this guidance. The risk of community COVID-19 transmission into the shelters increases with increased in and out movement of individuals. When operating under a high testing capacity, knowing the COVID-19 infection status informs cohorting decisions in the facility. However, admissions testing applies only to individuals who have not already been identified as COVID-19 positive. Once an individual is identified as COVID-19 positive, no additional testing is needed. The following testing guidance is provided, listed by priority:

- Symptom and temperature screen all admissions and immediately isolate if symptomatic or febrile >100.4. Testing should be offered as quickly as possible. Clients with symptoms consistent with COVID can be referred to dedicated medical shelters if available or cohorted separately and monitored for 14 days before being regrouped with the rest of the residents.
- Symptomatic individuals who decline testing should be referred out to dedicated medical shelters if available or cohorted separately and monitored for 14 days before being regrouped with the rest of the residents
- Test asymptomatic new admissions coming from the general community or unsheltered population if they have not had a negative test within the past 7 days. Those clients who refuse testing should be quarantined for 14 days prior to being regrouped with the rest of the residents.
- Test asymptomatic re-entry residents if they have not had a negative test result within the past 7 days. Those clients who refuse testing should be quarantined for 14 days prior to being regrouped with the rest of the residents.
- Asymptomatic new admissions released from facilities after completing isolation and/or quarantine do not need admissions testing but may be offered testing to determine COVID-19 infection status if the individual was never tested before.

Established residents

Depending on whether the residents are following “shelter in place” orders and staying inside at the housing facility OR come and go, admissions testing may be deferred in favor of daily symptom and temperature screening coupled with weekly surveillance testing in a subset of residents as follows:

- Symptom screen residents twice daily, and test individual immediately if symptomatic.



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- Test a proportion, such as 10-20%, of asymptomatic residents every week for surveillance and early detection of infection within the site. If the facility is small, consider testing all residents if site is operating at high testing capacity.
- Asymptomatic surveillance testing can be approached via a random sampling of residents, rotating weekly testing to attempt to cover all residents in a facility within a one-month period.
- Asymptomatic surveillance testing can also include a targeted component with purposeful inclusion of individuals with higher transmission potential such as:
 - residents who have activities or duties involving higher potential contact with others in the shelter.
 - medically vulnerable residents, particularly if they reside together in the facility.
 - re-entry residents, such as those who leave during the day for any reason, including work, medical visits, or other activities, and return at curfew.
- The specific selection of residents to be tested during surveillance will vary somewhat according to the testing acceptance, the specific resident activities, and resident demographics at each facility.

Staff

- Symptom screen staff twice daily and test symptomatic individuals or refer out for testing immediately if symptomatic.
- Test 25% of asymptomatic staff every week for surveillance and early detection of infection, ideally rotating staff tested so that all staff are tested at least once a month. If number of staff is less than 20, consider testing all staff weekly while operating under high testing capacity.
- Targeted testing of staff can be considered, focusing on staff who have increased contact with other persons by the nature of their job. These higher risk staff could be tested weekly.

Limited testing capacity:

When testing resources are limited, the testing approach focuses on symptomatic persons most likely to have COVID-19 infection. Facility managers and clinical teams providing services can adopt select portions of the high testing capacity guidance and provide a blend of high and limited testing capacity approaches as befits their testing capacity.

Residents and Staff

- Symptom and temperature screen residents and staff twice daily. Isolate resident immediately if symptomatic or febrile. Test or refer out for testing as soon as possible. Send staff home immediately if symptomatic or febrile and refer out for testing as soon as possible.

C. Encampments – Outbreak Identified / Active Investigation

Encampments are defined as areas not meant for human habitation where people experiencing homelessness reside. An encampment includes a group of individuals, usually in close proximity, living on the streets, tents, or recreational vehicles, with shared social activities that puts them into regular close contact with one

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another. Where an outbreak has been identified, the Department of Public Health will investigate the site and work with partners to complete testing, isolation, and quarantine of individuals for rapid infection control. When there are persons who are unwilling to leave the encampment for fear of loss of their belongings or of their preferred encampment location, the County will take a harm reduction approach and support these individuals to shelter in place as much as possible.

High testing capacity:

- Test all willing persons at the encampment as soon as possible, regardless of symptoms.
- For those who test negative or refuse testing, continue to offer weekly testing until no additional cases or symptomatic individuals are identified and the outbreak has been determined as controlled.
- Test all willing staff, regardless of symptoms, who worked at the encampment during the exposure dates if they were not wearing PPE or had a breach of PPE. For those who test negative or refused testing, offer repeat testing weekly or quarantine at home, respectively.

Limited testing capacity:

- Test all willing persons at the encampment who are symptomatic.
- Test select contacts of individuals known to be infected based on proximity to confirmed case and identification of immediate close contacts (e.g. general vicinity within the encampment, social group within the encampment, etc.)
- Test all willing staff, regardless of symptoms, who worked at the encampment during the exposure dates if they were not wearing PPE or had a breach of PPE. For those who test negative or refused testing, offer repeat testing weekly or quarantine at home, respectively.

D. Encampments – No Outbreak Identified

Encampments are defined as areas not meant for human habitation where people experiencing homelessness reside. An encampment includes a group of individuals, usually in close proximity, living on the streets, tents, or recreational vehicles, with shared social activities that puts them into regular close contact with one another. Where no outbreak has been identified, proactive outreach, wellness and symptom checks, coupled with increased routine testing at encampments can help identify cases earlier and potentially minimize transmission. Encampments that are large and densely populated should be prioritized as the risk for transmission increases with increased density and size. The general approach is to test a sample of persons not previously known to be COVID-19 positive to allow for detection of outbreaks. The target number of tests will vary according to the size of the encampment and testing resources.

The following are suggested approaches, but less frequent testing or fewer tests conducted might be necessary even while operating at a high testing capacity based on other factors such as test acceptance or other developments in the COVID-19 pandemic. As a general guide, surveillance testing in encampments without identified outbreaks can be carried out as follows:

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High testing capacity:

Residents

- For the largest encampments that are greater than 50 persons, consider testing at least 25% of the residents every week, and rotate through individuals so that every willing person can be tested at least once a month.
- For large encampments between 30-50 persons, consider testing 50% of the residents every 2 weeks, rotating through individuals so that every willing person can be tested at least once a month.
- For the smaller encampments with fewer than 30 persons, consider testing every willing resident at monthly intervals.
- For individuals who did not want to be tested, repeat offer of testing with the next outreach event.
- Individuals who have been identified as socially connected to several other encampments or to congregate settings should preferentially be tested more frequently than once a month. If willing, these individuals should be included in the testing.

Staff

- Symptom screen staff twice daily and test immediately if symptomatic.
- Test 25% of asymptomatic staff every week for surveillance and early detection of infection, ideally rotating staff tested so that all staff are tested at least once a month. If number of staff is less than 20, consider testing all staff weekly while operating under high testing capacity.
- Targeted testing of staff at increased frequency can be considered as well, focusing on staff who have increased contact with other persons by the nature of their job, or who do not consistently wear PPE in their line of work. These higher risk staff could be tested weekly.

Limited testing capacity:

Residents

- Conduct regular symptom and temperature screens and refer symptomatic residents to medical shelters for isolation.
- If a single symptomatic individual has been identified, continue symptom and temperature screens in the area for the next 3-4 days and refer to medical shelters for testing.

Staff

- Symptom screen staff twice daily and test immediately if symptomatic.

E. Hotels/Motels Identified During Current State of Emergency for Medically Vulnerable People Experiencing Homelessness

Hotels and motels provide shelter for medically vulnerable people experiencing homelessness in single or double occupancy rooms with their own bathrooms. Hotels and motels with this type of set up are not congregate residential facilities, are significantly lower in COVID-19 transmission risk than other settings previously described in this guidance document, and therefore do not follow the same outbreak definitions and testing guidance as congregate settings and encampments. As with other business locations, the Department of Public Health will investigate if an outbreak has been identified and apply a targeted testing approach that focuses on immediate contacts of the identified cases.

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Routine or surveillance testing of asymptomatic persons, staff or residents, is not recommended. Testing in the absence of an outbreak is limited to testing newly identified symptomatic persons residing or working at the hotel as follows:

High testing capacity:

- Symptom and temperature screen staff and residents 2 times daily, and test immediately if symptomatic.

Limited testing capacity:

- Symptom and temperature screen staff and residents 2 times daily. Refer symptomatic residents to medical shelters for testing. Refer symptomatic staff to primary provider for testing and isolate from work.

F. Medical Shelters

Individuals referred to Medical Shelters are either confirmed COVID-19 cases, symptomatic persons suspected of COVID-19, or close contacts of cases, who are unable to safely isolate or quarantine in their prior residence. The medical shelters provide single occupancy rooms with their own bathrooms to their clients. Medical shelters for COVID-19 are not congregate residential facilities, are significantly lower in COVID-19 transmission risk than other settings previously described in this guidance document, and therefore do not follow the same outbreak definitions and testing guidance as congregate settings and encampments. Since the medical shelters are expressly for COVID-19 suspected and confirmed cases and contacts, the Department of Public Health will investigate an outbreak only if several cases are identified among the staff and will work with the site to determine the best testing approach based on exposure histories.

Routine or surveillance testing of asymptomatic staff is not recommended. Testing in the absence of an outbreak is limited to testing clients as follows:

High testing capacity:

- Upon arrival, test all clients who have not been tested previously to confirm COVID-19 infection status.
- Consider retesting symptomatic individuals who have tested COVID negative or indeterminate within the past 7 days.
- Test all individuals who were exposed to COVID and who were referred for quarantine because they are identified close contacts of cases.
- Routine retesting of patients who have documented COVID-19 positive results for test clearance is not recommended.

Limited testing capacity:

- Test only individuals who are required by Department of Public Health to have a test prior to returning to a quarantined facility that is undergoing an outbreak investigation.
- COVID-19 negative tests are not required for discharge of clients from medical shelters after they have completed the necessary isolation or quarantine.